



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
OLYMPIA, WASHINGTON 98504-0095

FAIR HEARING WITHDRAWAL

Date: _____

Assistance Unit Number: _____

Name: _____

Docket Number: _____

Address: _____
STREET CITY ZIP CODE

I hereby request that my Fair Hearing schedule for _____ on _____, _____.
TIME MONTH AND DAY YEAR

at _____ be withdrawn because:
COMMUNITY SERVICES OFFICE (CSO)

If you have any questions, please call _____, your Fair Hearing Coordinator, at
_____.

Please sign and return this withdrawal request in the enclosed postage paid envelope as soon as possible.

CLIENT'S SIGNATURE

TELEPHONE NUMBER